

State:	Arkansas	Filing Company:	Nationwide Life Insurance Company
TOI/Sub-TOI:	H12 Health - Excess/Stop Loss/H12.001 Accident & Sickness		
Product Name:	Stop Loss		
Project Name/Number:	Stop Loss Filing/		

Filing at a Glance

Company:	Nationwide Life Insurance Company
Product Name:	Stop Loss
State:	Arkansas
TOI:	H12 Health - Excess/Stop Loss
Sub-TOI:	H12.001 Accident & Sickness
Filing Type:	Form
Date Submitted:	01/24/2013
SERFF Tr Num:	NWLC-128860594
SERFF Status:	Closed-Approved-Closed
State Tr Num:	
State Status:	Approved-Closed
Co Tr Num:	GSL AO L20 000 0312
Implementation	On Approval
Date Requested:	
Author(s):	LaToyia Brooks
Reviewer(s):	Rosalind Minor (primary)
Disposition Date:	01/30/2013
Disposition Status:	Approved-Closed
Implementation Date:	
State Filing Description:	

State: Arkansas **Filing Company:** Nationwide Life Insurance Company
TOI/Sub-TOI: H12 Health - Excess/Stop Loss/H12.001 Accident & Sickness
Product Name: Stop Loss
Project Name/Number: Stop Loss Filing/

General Information

Project Name: Stop Loss Filing Status of Filing in Domicile: Pending
Project Number: Date Approved in Domicile:
Requested Filing Mode: Review & Approval Domicile Status Comments: Concurrently being filed in Nationwide's state of domicile, Ohio
Explanation for Combination/Other: Market Type: Group
Submission Type: New Submission Group Market Size: Large
Group Market Type: Blanket Overall Rate Impact:
Filing Status Changed: 01/30/2013
State Status Changed: 01/30/2013 Deemer Date:
Created By: LaToyia Brooks Submitted By: LaToyia Brooks
Corresponding Filing Tracking Number:

Filing Description:

We are filing the attached stop loss program for your review and approval for use with Policyholders in your state that self-fund the underlying health care plan. .

Form GSL AO L20 000 0312 is the stop loss contract. Form GSL AO L23 000 0312 is the application for stop loss coverage. Form GSL AO L23 001 0312 is the request for renewed stop loss coverage. Form GSL AO L24 000 0312 is the stop loss renewal amendment and provides for a revised policy schedule at renewal.

Company and Contact

Filing Contact Information

Latoyia Brooks, Sr. Compliance Analyst brookl10@nationwide.com
1 Nationwide Plaza 614-677-3871 [Phone]
Columbus, OH 43215

Filing Company Information

Nationwide Life Insurance CoCode: 66869 State of Domicile: Ohio
Company Group Code: 140 Company Type:
5525 Parkcenter Circle Group Name: State ID Number:
Dublin, OH 43017 FEIN Number: 31-4156830
(614) 854-3375 ext. [Phone]

Filing Fees

Fee Required? Yes
Fee Amount: \$50.00
Retaliatory? No
Fee Explanation:
Per Company: No

Company	Amount	Date Processed	Transaction #
Nationwide Life Insurance Company	\$50.00	01/24/2013	66837970
Nationwide Life Insurance Company	\$150.00	01/24/2013	66852592

State:	Arkansas	Filing Company:	Nationwide Life Insurance Company
TOI/Sub-TOI:	H12 Health - Excess/Stop Loss/H12.001 Accident & Sickness		
Product Name:	Stop Loss		
Project Name/Number:	Stop Loss Filing/		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	01/30/2013	01/30/2013

Objection Letters and Response Letters

Objection Letters

Status	Created By	Created On	Date Submitted
Pending Industry Response	Rosalind Minor	01/24/2013	01/24/2013

Response Letters

Responded By	Created On	Date Submitted
LaToyia Brooks	01/24/2013	01/24/2013

State:	Arkansas	Filing Company:	Nationwide Life Insurance Company
TOI/Sub-TOI:	H12 Health - Excess/Stop Loss/H12.001 Accident & Sickness		
Product Name:	Stop Loss		
Project Name/Number:	Stop Loss Filing/		

Disposition

Disposition Date: 01/30/2013

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Flesch Certification	Approved-Closed	Yes
Form	stop loss policy	Approved-Closed	Yes
Form	stop loss application	Approved-Closed	Yes
Form	renewal application	Approved-Closed	Yes
Form	renewal rider	Approved-Closed	Yes

State: Arkansas **Filing Company:** Nationwide Life Insurance Company
TOI/Sub-TOI: H12 Health - Excess/Stop Loss/H12.001 Accident & Sickness
Product Name: Stop Loss
Project Name/Number: Stop Loss Filing/

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	01/24/2013
Submitted Date	01/24/2013
Respond By Date	

Dear Latoyia Brooks,

Introduction:

This will acknowledge receipt of the captioned filing.

Objection 1

- stop loss policy, GSL AO L20 000 0312 (Form)
- stop loss application, GSL AR L23 000 0312 (Form)
- renewal application, GSL AO L23 001 0312 (Form)
- renewal rider, GSL AO L24 000 0312 (Form)

Comments:

Our filing fees under Rule and Regulation 57 have been updated. Please review the General Instructions for ArkansasLH or Rule and Regulation 57.

The fee for this submission is \$50.00 per form for a total of \$200.00. Please submit an additional \$150.00 for this submission.

We will begin our review of this submission upon receipt of the additional filing fee.

Conclusion:

A.C.A. 23-79-109(1)-(5) sets forth the procedure by which filings may be deemed approved upon the expiration of certain time periods with no affirmative action by the commissioner. If the commissioner determines that additional information is needed to make a decision regarding approval, such request for information will be made to the company. The filing will not be considered complete until said additional information is received. The time periods set forth in this statute will not begin to run until the filing is complete.

Please feel free to contact me if you have questions.

Sincerely,

Rosalind Minor

State: Arkansas **Filing Company:** Nationwide Life Insurance Company
TOI/Sub-TOI: H12 Health - Excess/Stop Loss/H12.001 Accident & Sickness
Product Name: Stop Loss
Project Name/Number: Stop Loss Filing/

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	01/24/2013
Submitted Date	01/24/2013

Dear Rosalind Minor,

Introduction:

Response 1

Comments:

The additional fees were submitted

Related Objection 1

Applies To:

- stop loss policy, GSL AO L20 000 0312 (Form)
- stop loss application, GSL AR L23 000 0312 (Form)
- renewal application, GSL AO L23 001 0312 (Form)
- renewal rider, GSL AO L24 000 0312 (Form)

Comments:

Our filing fees under Rule and Regulation 57 have been updated. Please review the General Instructions for ArkansasLH or Rule and Regulation 57.

The fee for this submission is \$50.00 per form for a total of \$200.00. Please submit an additional \$150.00 for this submission.

We will begin our review of this submission upon receipt of the additional filing fee.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Conclusion:

Sincerely,
LaToyia Brooks

SERFF Tracking #:

NWLC-128860594

State Tracking #:

Company Tracking #:

GSL AO L20 000 0312

State: Arkansas

TOI/Sub-TOI: H12 Health - Excess/Stop Loss/H12.001 Accident & Sickness

Product Name: Stop Loss

Project Name/Number: Stop Loss Filing/

Filing Company:

Nationwide Life Insurance Company

Form Schedule

Lead Form Number: GSL AO L20 000 0312

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
1	Approved-Closed 01/30/2013	stop loss policy	GSL AO L20 000 0312	POL	Initial		46.300	GSL AO L20 000 0312 - Stop Loss Policy.pdf
2	Approved-Closed 01/30/2013	stop loss application	GSL AR L23 000 0312	AEF	Initial		0.000	GSL AR L23 000 0312 - Stop Loss Application.pdf
3	Approved-Closed 01/30/2013	renewal application	GSL AO L23 001 0312	AEF	Initial		0.000	GSL AO L23 001 0312 - Stop Loss Renewal App.pdf
4	Approved-Closed 01/30/2013	renewal rider	GSL AO L24 000 0312	POLA	Initial		47.900	GSL AO L24 000 0312 - Stop Loss Renewal Amendment.pdf

Form Type Legend:

ADV	Advertising	AEF	Application/Enrollment Form
CER	Certificate	CERA	Certificate Amendment, Insert Page, Endorsement or Rider
DDP	Data/Declaration Pages	FND	Funding Agreement (Annuity, Individual and Group)
MTX	Matrix	NOC	Notice of Coverage
OTH	Other	OUT	Outline of Coverage
PJK	Policy Jacket	POL	Policy/Contract/Fraternal Certificate

State:	Arkansas	Filing Company:	Nationwide Life Insurance Company
TOI/Sub-TOI:	H12 Health - Excess/Stop Loss/H12.001 Accident & Sickness		
Product Name:	Stop Loss		
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POLA	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	SCH	Schedule Pages
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Nationwide Life Insurance Company

Home Office: Columbus, Ohio

STOP LOSS INSURANCE CONTRACT

On Your Side®

Nationwide Life Insurance Company ("Company") agrees to reimburse the Policyholder as outlined under the provisions of this Stop Loss Insurance Contract ("Contract").

Policyholder:

Contract Number:

Effective Date:

Anniversary Date:

And the same day each year thereafter.

This Contract is legally binding between the Policyholder and the Company. The consideration for this Contract includes, but is not limited to, the Application and the payment of premiums as provided hereinafter.

The Policyholder is entitled to the reimbursement determined in this Contract if the Policyholder is eligible for insurance under the provisions of this Contract. Reimbursement is subject to the terms and conditions of this Contract.

The first premium is due on the first day of the Contract Period. Subsequent premiums are due on the first day of each month thereafter. The premium is not considered paid until the premium payment is received by the Company.

All periods of coverage will begin and end 12:01 a.m. Standard Time at the principal office of the Policyholder.

This Contract is governed by the laws of the state of _____.

The sections set forth on the following pages are a part of this Contract.

IN WITNESS WHEREOF, the Company has caused this Contract to be executed at [_____].

[_____]

[
Secretary

]

[
President

]

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SCHEDULE OF STOP LOSS

Coverage specified herein is applicable only during the Contract Period from _____ to _____, and is further subject to all terms and conditions of this Contract, unless annotated below.

[AGGREGATE STOP LOSS] ☐ Yes ☐ No

Benefit Period: Covered Person's Benefit Plan Losses Incurred from _____ through _____, and Paid from _____ through _____.

[Losses Incurred prior to the original Contract Effective Date will be limited to \$ _____ and \$ _____ per Covered Person.]

Coverages applying to Aggregate Stop Loss include:

- | | |
|--|--|
| <input type="checkbox"/> Medical | <input type="checkbox"/> [Prescription Drug Card Program] |
| <input type="checkbox"/> [Dental Care] | <input type="checkbox"/> [Mail Order Prescription Drug Card Program] |
| <input type="checkbox"/> [Vision Care] | <input type="checkbox"/> [Weekly (Disability) Income] |
| <input type="checkbox"/> [Other] _____ | |

[Aggregate Percentage Reimbursable (Excess of Attachment Point) _____ %]

Monthly Aggregate Factors:

	Covered Person	Covered Person & Child(ren)	Covered Person & Spouse [Domestic Partner]	Covered Person & Family
Medical	\$ _____	\$ _____	\$ _____	\$ _____
[Dental	\$ _____	\$ _____	\$ _____	\$ _____]
[Vision	\$ _____	\$ _____	\$ _____	\$ _____]
[Weekly Disability	\$ _____	\$ _____	\$ _____	\$ _____]
Other _____	\$ _____	\$ _____	\$ _____	\$ _____

[All coverages are combined for determination of Aggregate Stop Loss liability under the terms of this Contract.]

[Maximum Aggregate Benefit per Benefit Period \$ _____
(Excess of Annual Aggregate Attachment Point)]

[Maximum Benefit Plan Losses per Covered Person per Benefit Period
\$ _____]

[Minimum Annual Aggregate Attachment Point \$ _____]

[Aggregate Premium per (month/annum/per Covered Person per month) \$ _____]]

[SPECIFIC STOP LOSS] ☐ Yes ☐ No

Benefit Period: Covered Person's Benefit Plan Losses Incurred from _____ through _____ and Paid from _____ through _____.

[Losses Incurred prior to this Contract Effective Date will be limited to _____ per Covered Person.]

Coverage applying to Specific Stop Loss include:

- | | |
|--|--|
| <input type="checkbox"/> Medical | <input type="checkbox"/> [Prescription Drug Card Program] |
| <input type="checkbox"/> [Dental Care] | <input type="checkbox"/> [Mail Order Prescription Drug Card Program] |
| <input type="checkbox"/> [Vision Care] | <input type="checkbox"/> [Weekly (Disability) Income] |

☐ [Other]_____

Specific Deductible (per Person) \$_____

Specific Percentage Reimbursable (Excess of Deductible) _____

Lifetime Maximum Specific Benefit \$_____
(per Covered Person in excess of the Specific Deductible)

Specific Premium per month:	Covered Person Only	\$_____
	Covered Person & Child(ren)	\$_____
	Covered Person & Spouse	\$_____
	Covered Person & Family	\$_____]

[SPECIAL CONDITIONS AND/OR LIMITATIONS:]

THIRD PARTY ADMINISTRATOR:

Dated at _____ this _____ day of _____, [YYYY]

Policyholder _____

Title _____

Witness _____

DEFINITIONS

[AGGREGATE STOP LOSS] means the amount that the Company agrees to reimburse the Policyholder after the end of the Contract Period for Losses Paid by the Policyholder over and above the Policyholder's Annual Aggregate Attachment Point as set forth in the Schedule of Stop Loss, and subject to the terms and conditions of the Contract.]

[ANNUAL AGGREGATE ATTACHMENT POINT] for any one Contract Period means the greater of:

- the sum of the Monthly Aggregate Attachment Point; or
- the Minimum Annual Aggregate Attachment Point.]

BENEFIT PERIOD means the period of time in which a claim must be Incurred by the Covered Person and Paid by the Plan to be eligible for reimbursement under the Policyholder's Stop Loss Contract. This period does not alter the Effective Date, Contract Period, or waive the Contract's eligibility requirements.

CONTRACT PERIOD means the specified period in the Schedule of Stop Loss, beginning no earlier than the Effective Date of the Contract and continuing until coverage terminates in accordance with the Contract Termination provision.

COVERED PERSON means any one individual covered under the specific terms and provisions of the Covered Person's Benefit Plan. Only eligible classes and individual(s) whose initial and continued eligibility is fully described in the copy of the Plan on file with the Company shall be considered a Covered Person.

COVERED PERSON'S BENEFIT PLAN (also known as the Plan) means the self-funded plan of benefits provided by the Policyholder for Covered Persons for the coverage(s) indicated as applicable to the [Aggregate] [Specific] Stop Loss as set forth in the Schedule of Stop Loss. A copy of the Plan or plans in effect on the Contract Effective Date is on file with the Company and made a part of this Contract.

COVERED UNIT means the following person or persons who are covered under the Plan:

- [a Covered Person;]
- [a Covered Person with dependents][; or]
- [such other defined unit as agreed upon between the Company and the Policyholder.]

INCURRED means the date on which the Services Are Rendered or supplies are received by the Covered Person. [Inpatient facility charges with continuous facility stay, that fall over two or more Contract years will be considered on a pro rata/per diem basis by dividing the total amount of eligible charges by the total number of days of confinement and multiplying by the number of days of confinement in each Contract year.] [For inpatient hospital/facility charges and professional fees provided during an inpatient stay a claim is considered incurred on the date the Covered Person is discharged from the hospital/facility.]

[LATE ENTRANT] is an eligible Covered Person who requests coverage in the Covered Person's Benefit Plan more than 30 days after the date the person was first eligible to enroll. [A person shall not be considered a Late Entrant if he:

- was covered under another Policyholder's [group] health plan at the time of initial enrollment; and
- stated at the time of initial enrollment that coverage under another Policyholder's [group] health plan was the reason for declining coverage; and
- has lost coverage under another Policyholder's [group] health plan due to loss of eligibility; and
- requests coverage within 30 days after termination of such coverage; [or
- applies for coverage on a spouse or minor child within 30 days of a court order requiring coverage be provided under the Plan].]

LOSS, LOSSES means Reasonable and Customary Charges actually Paid by the Policyholder for eligible benefits under the Plan.

[MAXIMUM AGGREGATE BENEFIT means the maximum amount reimbursable by the Company to the Policyholder for the Contract Period.]

[MINIMUM ANNUAL AGGREGATE ATTACHMENT POINT means the lowest amount of the Policyholder's responsibility for the Contract Period, as set forth in the Schedule of Stop Loss, for Losses under the Plan.]

[MONTHLY AGGREGATE ATTACHMENT POINT means the total number of Covered Units for that given Contract month multiplied by the corresponding Monthly Aggregate Factors as specified in the Schedule of Stop Loss. [However, in the event of a reduction in the number of Covered Units under the Plan, the Monthly Aggregate Attachment Point will not be reduced more than [five percent] from the preceding Monthly Aggregate Attachment Point.]]

PAY, PAID, PAYMENT means that a claim has been adjudicated by the TPA and the funds are actually disbursed by the Plan prior to the end of the Benefit Period. Payment of a claim is the unconditional and direct payment of a claim to a Covered Person or their health care provider(s). Payment may be deemed made on the date that both: 1) the payor directly tenders payment by mailing (or by other form of delivery) a draft or check; and 2) the account upon which the payment is drawn contains, and continues to contain, sufficient funds to permit the check or draft to be honored by the institution upon which it is drawn.

POLICYHOLDER is the legal entity to whom the Company has issued the Contract.

PROOF OF LOSS is documentation evidencing a Loss as required in the claim submission forms furnished by the Company.

REASONABLE AND CUSTOMARY CHARGE(S) means the usual charge made by the provider of care for a service, not to exceed the usual charge made by the majority of like providers for the same or like service in the same geographical area in which the service or treatment is performed. If the Plan has a contracted fee arrangement with certain health care providers, "Reasonable and Customary Charges" shall mean the lesser of the applicable fee as defined in that fee arrangement contract or the usual charge made by the majority of like providers for the same or like service in the same geographical area in which the service or treatment is performed.

[SPECIFIC DEDUCTIBLE means the amount of the Policyholder's responsibility for each Covered Person under the Plan during the Benefit Period as specified in the Schedule of Stop Loss. For each Covered Person, the Specific Deductible will apply separately to each Benefit Period. If this Contract terminates during any Contract Period, the Specific Deductible will be calculated as if this Contract had remained in effect for the full Contract Period.]

[SPECIFIC STOP LOSS means the amount the Company will reimburse the Policyholder for eligible Losses Paid by the Policyholder over and above the Specific Deductible for a Covered Person while this Contract is in force as set forth in the Schedule of Stop Loss, and subject to the terms, conditions and limitations of this Contract.]

SERVICES ARE RENDERED means the date the services were provided. [or; for inpatient stays, the date of discharge].

THIRD PARTY ADMINISTRATOR means a firm or person which has been retained by the Policyholder to pay claims and/or provide administrative services on behalf of the Policyholder Plan. Administrator in this definition does not have the same meaning as the term "Plan Administrator" used in the Employee Retirement Income Security Act of 1974 (ERISA), unless the Policyholder has specifically appointed their Administrator to perform as such.

DUTIES OF THE POLICYHOLDER

DUTIES OF THE POLICYHOLDER in this Contract are conditions precedent to the Company's liability. No reimbursement shall be payable unless, the conditions precedent have been met.

THIRD PARTY ADMINISTRATOR: The Policyholder may retain a Third Party Administrator, who is approved by the Company, to act as the Policyholder's agent in performing administrative duties on behalf of the Policyholder. Without waiving any of its rights under this Contract, and without making the designated Third Party Administrator a party to this Contract, the Company and the Policyholder agree to recognize the Third Party Administrator as an agent for the Policyholder.

PAYMENT OF CLAIMS: The Policyholder must Pay all eligible claims under the Plan within [sixty] [forty-five] days from the date adequate proof is provided to the Policyholder. If the Policyholder fails to pay claims within the [sixty][forty-five]-day time limit, that claim will not count towards the satisfaction of either the Annual Aggregate Deductible (Attachment Point) or the Specific Deductible or be reimbursed under this Contract and the Company will have the option to terminate this Contract

COOPERATION WITH AUDITS: The Policyholder and its Third Party Administrator must cooperate with the Company in the event the Company exercises its right to audit as set forth in this Contract.

NOTICE OF CLAIM: Policyholder's written Proof of Loss must be submitted to the Company within 90 days of it being Paid by the Policyholder

LITIGATION: A copy of any document filed by or against the Policyholder in any court in connection with litigation under the Plan must be promptly furnished to the Company. The Policyholder shall pay all attorneys' fees and any punitive or exemplary damages incurred under this Contract by reason of any litigation in which the Company shall, without its fault, become involved through or on account of this Contract or the Plan.

TAXES: In the event any taxing authority which has jurisdiction over either of the parties finds that Additional Taxes must be paid in respect of this Contract, the Plan, or related matters, the Policyholder shall be responsible for such Additional Taxes. An amount equal to the total amount to be paid because of such Additional Taxes shall be promptly paid by the Policyholder to the Company upon written request. "Additional Taxes" means those which are in addition to the premium taxes paid by the Company with respect to this Contract.

REPORTING REQUIREMENTS: The Policyholder will submit by the 12th day of each month or as soon as reasonably possible but no longer than 30 days all Proof of Loss reports and supporting documents including, but not limited to, a monthly summary of all Losses Paid by the Policyholder and total number of Covered Units covered under the Plan during the prior month. The Policyholder will be responsible for the investigation, auditing, calculating and the Payment of all claims under the Plan.

RECORDS: The Policyholder will maintain records of all Covered Persons under the Plan during the Contract Period and for a period of seven years after the termination of this Contract. The Policyholder shall make such records available to the Company as needed to evaluate its liability under this Contract.

The Policyholder will maintain a separate record of any and all amounts Paid in excess of benefits eligible under the Plan.

TERMINATION: The Policyholder will immediately notify the Company if the Policyholder's Plan is terminated.

[TIMELINESS: Time is of the essence. The Policyholder must comply with all deadlines stated in this Contract.]

MISCELLANEOUS PROVISIONS

AMENDMENT TO THE PLAN: No Plan change will affect this Contract without the Company's written consent. Written notice of the Plan change must be given to the Company prior to the effective date of the change. If such advance written notice is not received and accepted, the Company's reimbursement may be made as if the Plan had not been amended, at the Company's discretion. The Company's reimbursement will be made according to the amended Plan, once the notice is received and accepted.

AUDITS: The Company will have the right:

- to inspect, copy and audit all records and procedures of the Policyholder and Third Party Administrator developed and maintained for the Plan that are applicable to the administration of the Stop Loss Insurance Contract, and
- to require, upon request, proof of records satisfactory to the Company that Payment has been made to the Covered Person or the provider of such services or benefits which are the basis for any Loss by the Policyholder hereunder.

CHANGES: This Contract can be altered only with the consent of the Company and then only in writing. No such alteration of this Contract shall be valid unless endorsed on or attached to this Contract. No Agent, Broker, or Third Party Administrator has the authority to alter this Contract or to waive any of its provisions, including premiums shown in the Schedule of Stop Loss.

CHANGES TO MANAGED CARE: If the Plan or its third party administrator has a contracted fee arrangement with certain health care providers and/or hospitals and the contract is terminated or cancelled or the charges or fee schedule allowed under the contract is increased, the Policyholder or Third Party Administrator shall notify the Company [within 10 days of the Policyholder's or Third Party Administrator's notice] [at least 31 days prior to the effective date] of such an occurrence. The Company shall have the right to adjust the premium rates and/or the Specific Deductible amount and/or the Annual Aggregate Attachment Point. If such notice is not given, the Company's liability for contract changes shall be deemed the lesser of the new contract or the contract charges prior to the cancellation, termination or change.

CLERICAL ERROR: Clerical error, inadvertent delay or omission in keeping any records pertaining to the coverage, whether by the Policyholder or by the Company, will not invalidate coverage otherwise validly in force nor continue coverage otherwise validly terminated, provided such clerical error, inadvertent delay or omission is not prejudicial to the Company and is rectified promptly upon discovery.

CONCEALMENT, FRAUD: This entire Contract will be void if, the Policyholder or its agent has concealed or misrepresented any material fact or circumstance concerning this Contract, including any claim or any case of fraud by the Policyholder or its Third Party Administrator or other Agent relating to this Contract.

ENTIRE CONTRACT: The entire Contract between the Company and the Policyholder will consist of this Contract, the Application (including the Disclosure Statement), approved amendments and riders, and the Policyholder's Plan Document which is on file with the Company.

INSOLVENCY: The insolvency, bankruptcy, financial impairment, receivership, voluntary plan of arrangement with creditors, or dissolution of the Policyholder or the Policyholder's Third Party Administrator will not impose upon the Company any liability other than the liability defined in this Contract. In particular, the insolvency of the Policyholder will not make the Company liable to the creditors of the Policyholder, including Covered Persons under the Plan.

LEGAL ACTION: No legal action may be brought against the Company until there has been full compliance with all the terms of this Contract. All Contract terms will be interpreted under the laws of the state shown on page 1 of this Contract. No legal action may be brought to recover on this Contract within 60 days after written Proof of Loss has been furnished. No legal action may be brought after three (3) years from the time written Proof of Loss is required to be furnished. Venue for any legal action filed by either party under this Contract shall be located in Columbus, Ohio.

LIABILITY: The Company will have neither the right nor the obligation under this Contract to directly pay any Covered Person or provider of professional or medical services. The Company's sole liability is to the Policyholder, subject to the terms and conditions of this Contract. Nothing in this Contract shall be construed to permit a Covered Person to have a direct right of action against the Company. The Company will not be considered a party to the Covered Person's Benefit Plan or to any supplement or amendment to it. The Policyholder may not assign reimbursement under this Contract, and the Company will not recognize any such assignment.

MISSTATED DATA: The Company has relied upon the underwriting information provided by the Policyholder, its Third Party Administrator or other Agent in the issuance of this Contract. Should subsequent information become known which, if known prior to final underwriting of this Contract, would have affected the rates, deductibles, terms or conditions for coverage, the Company will have the right to revise the rates, deductibles, terms or conditions as of the Effective Date of issuance, by providing written notice to the Policyholder.

NON-CONFLICTING LANGUAGE WITH PLAN AND STOP LOSS CONTRACT: Any provision in the Plan which purports to alter or conflict with the terms, conditions or provision of this Contract shall be null and void insofar as it might affect the Company's liability under this Contract.

NOTICE: For the purpose of any notice required from the Company under the provisions of this Contract, notice to the Policyholder's Third Party Administrator shall be considered notice to the Policyholder and notice to the Policyholder shall be considered notice to the Policyholder's Third Party Administrator. Notice from the Policyholder to the Company's designee and notice from the Third Party Administrator to the Company's designee shall be considered notice to the Company. Notice from the Policyholder to the Policyholder's Third Party Administrator and notice from the Third Party Administrator to the Policyholder shall not be considered notice to the Company.

OFFSET: Any payment or overpayment of a claim made to the Policyholder due to error or mistake must be promptly refunded to the Company upon notice to the Policyholder of such error or mistake. The Company may offset any refund owed to the Company for such payment or overpayment or any premium owed to the Company against any reimbursement due the Policyholder.

OTHER COVERAGE: The reimbursement provided by this Contract is in excess of other coverages such as group insurance, excess insurance, reinsurance, plan benefits including insurance or benefits established by any federal, state or local law.

OVER-REIMBURSEMENT, THIRD PARTY RECOVERY, OTHER CARRIER LIABILITIES: Amounts Paid which are reimbursed by, or payable by other insurance companies, reinsurers or third parties will not be included in Aggregate Stop Loss or Specific Stop Loss.

- Should there be a recovery of Paid claims due to a subrogation, reimbursement, or third party liability provision in the Plan, the amount of recovered Plan payments will not apply to Specific Stop Loss or Aggregate Stop Loss. The Company will not reimburse amounts recovered. If the Company reimburses the Policyholder for amounts that are later recovered from a third party payer, the amount recovered must be refunded by the Policyholder to the Company to the extent of any reimbursement, whether or not this Contract is still in force on the date the recovery is received.
- Should there be an over-reimbursement made to the Policyholder due to clerical or other error, the over-reimbursement must be refunded.
- If benefits for a Covered Unit are payable under an extension of benefits provision of a previous insurance carrier, the Company will not accept responsibility for the expenses payable under the prior coverage for such individuals.

PARTIES TO THE CONTRACT: The parties to this Contract are the Policyholder and the Company. The Company's sole liability under this Contract is to the Policyholder. This Contract does not create any right or legal relation between the Company and a Covered Person under the Covered Person's Benefit Plan. This Contract will not be deemed to make the Company a party to any agreement between the Policyholder and any Third Party Administrator.

RENEWAL: At the end of the Contract Period, but only by mutual agreement of the Policyholder and the Company, this Contract may be renewed for another Contract Period. The renewal may be subject to new premium rates, new underwriting terms, a new Benefit Period and new Contract terms. Company approval of a continuance request by the Policyholder for Stop Loss Insurance resulting in a new Contract Period, Benefit Period and new Contract terms and conditions will affect a new Schedule of Stop Loss.

SEVERABILITY CLAUSE: Any clause deemed void, voidable, invalid, or otherwise unenforceable, whether or not such a provision is contrary to public contract, will not render any of the remaining provisions of this Contract invalid.

SUBROGATION: The Policyholder has the sole obligation to pursue, to the full extent of the legal remedies available to it, all claims that it may have against third parties when they arise out of an occurrence which results in a Loss. Should the Policyholder fail to pursue a claim that it may have against a third party, and should it not otherwise pursue all legal remedies available to it and should the Company then become liable to make payments under the terms and conditions of this Contract, then the Company shall determine its payment under this Contract as if the Policyholder had in fact pursued its legal remedies and had been successful.

WAIVER: Failure of the Company to insist upon the Policyholder's strict compliance with any requirement or condition of this Contract at any time or under any circumstance shall not constitute a waiver of such requirements or condition by the Company at any time under the same or different circumstances.

EXCLUSIONS

Losses under the Plan shall not include, and the Company shall not be liable for, any of the following.

1. Court costs, interest upon judgments, cost of investigations or other claims administration costs, legal expenses and punitive or other damages assessed against, or incurred by, the Policyholder, Third Party Administrator or other party associated with the Plan.
- [2. Amounts Paid for Covered Persons who [are not Actively At Work unless agreed to in writing by the Company.]
3. Amounts Paid for
 - any individual who is not eligible for benefits under the Plan;
 - any services or supplies, rendered to a Covered Person, when such service or supply is not a covered service under the Plan.
4. Amounts Paid for Covered Persons which are in excess of Reasonable and Customary Charges.
5. Claims arising out of or caused by or contributed to or in consequence of war or act of war, declared or not, hostilities, invasion or civil war.
6. Claims arising out of or in the course of any occupation or employment for wage or profit for which the Covered Unit is entitled to benefits under any Workers' Compensation or Occupational Disease Act or Law.
7. Claims arising out of nuclear accident.
8. Any managed care discount, negotiated discount, audit savings or other discount or savings forfeited or waived by the Policyholder for any reason, including but not limited to untimely payment.
- [9. Experimental or Investigative services, treatments, procedures, technology, supplies or drugs which:
 - have not been approved by the Federal Food and Drug Administration;
 - are not widely recognized and accepted as effective, safe and appropriate for the sickness or injury by the medical profession in the U.S.;
 - are in the research or investigative stage, or conducted for research or similar purposes; or
 - the patient has been asked to sign or has signed a release or other document indicating that the treatment is Experimental or Investigative or other term of similar meaning.

In determining any of the above, the Company will rely on recognized medical sources such as, but not limited to, the American Medical Association, including the Council of Technology Assistance Program and the Council on Medical Special Services; the National Institute of Health; Medicare; the Food and Drug Administration and other accepted medical authorities and sources.]

10. The Company shall not be liable for:
 - Amounts Paid for claims submitted to or Paid by the Plan, more than [365] days after the services were Incurred.
 - Amounts Paid for Losses where evidence of Payment satisfactory to the Company of such Loss was submitted to the Company more than [90] days after the Benefit Period.
- [11. Amounts paid for Covered Persons who reside outside of the United States unless agreed to in writing by the Company.]
- [12. Notwithstanding the clerical error provision under Miscellaneous Provisions, this Contract shall exclude any amounts Paid for Covered Persons, whose coverage is continued outside of the parameters specified by Federal Law under the Consolidated Omnibus Budget Reconciliation Act (hereafter referred to as COBRA) [for any reason including clerical error of the Policyholder; who do not receive a valid COBRA extension offer within the 30 days immediately following a COBRA qualifying event; who fail to make a valid, signed COBRA election within the 60 days immediately following the receipt of COBRA election rights from the Policyholder; or who fail to remit COBRA premium within the period specified by federal law]. The Company will require written documentation that these requirements have been satisfied.]
- [13. [Salaries] [Fees] paid to [Covered Persons of] [the Policyholder or of] the Third Party Administrator and any other Policyholder contracted services.]
- [14. Amounts Paid under the Plan for a Covered Unit whose evidence of good health as a Late Entrant is not approved by the Company.]

- [15. Amounts Paid under the Plan which would not have been Paid if benefits were coordinated according to the National Association of Insurance Commissioners (NAIC) Model COB Guidelines.]
- [16. Amounts Paid for treatment not due to sickness or injury, including cosmetic surgery or any treatment to correct complication of cosmetic surgery except cosmetic surgery required to correct birth defect of a child born to or adopted by a Covered Person while his coverage under the Plan is in force; or cosmetic surgery to correct the result of a non-cosmetic surgery that results in deformity, trauma, infection or disease of the involved party.]
- [17. Amounts Paid as benefits for inpatient or outpatient stays for alcohol or drug abuse and mental or nervous disorders in excess of the lesser of:
 - [30] inpatient and [30] outpatient stays during a Contract year; or
 - the number of stays or the amount payable under the Plan.]
- [18. Claims which were Incurred prior to the start of the first Contract year, whether advised of at that time or later, unless specifically covered by the terms of this Contract.]
- [19. All claims for hospital expense for confinements that commenced prior to the Effective Date of this Contract. This exclusion shall apply even when the date of discharge occurs after the Effective Date; and the confinement would otherwise be considered a service Incurred for purposes of this Contract.]

PREMIUMS AND FACTORS

PAYMENT OF PREMIUMS: No coverage under this Contract will be in effect until the first premium is paid. For coverage to remain in effect, each subsequent Payment, as shown in the Schedule of Stop Loss for the applicable Contract Period, must be paid on or before its due date. The Policyholder is responsible for the Payment of its premiums. Premiums are not considered paid until the premium Payment is received by the Company.

GRACE PERIOD: A Grace Period of [31] days from the due date will be allowed for the Payment of each premium after the first premium Payment. During the Grace Period, the coverage will remain in effect provided the premium is paid before the end of the Grace Period. Should a premium otherwise due, not be paid during the Grace Period, this Contract will be terminated without further notice, as of the date for which premiums were last paid.

PREMIUM AMOUNT: The Policyholder's premiums will be calculated using rates determined by the Company as set forth in the Schedule of Stop Loss. The amount of total premium due is the sum obtained by multiplying each rate shown in the Schedule of Stop Loss by the Covered Units to which the rate applies.

The Policyholder will be liable for any premium taxes assessed at any time against the Company above any taxes which may be payable on the premium received by the Company.

Any correction to the Specific or Aggregate premium of the Covered Units for the preceding Contract Period, must be reported to the Company within [ninety] [sixty days] after the last Contract month of the preceding Contract Period.

PREMIUM RATE AND MONTHLY AGGREGATE FACTOR CHANGE: The Company may change the Policyholder's premium rate or Monthly Aggregate Factor on any of the following:

- [the date when the terms of this Contract are changed; or]
- [the date the Policyholder adds or deletes subsidiary or affiliated companies or divisions; or]
- the date of any revision to the Covered Person's Benefit Plan; or]
- [the date there is any change in the factors bearing on the risk assumed; or]
- [the date there is a change in enrollment exceeding [10]% of the first month's enrollment of the current Contract Period or the 9th month of the prior Contract Period.]

The Company reserves the right to recalculate the premium rate and the Monthly Aggregate Factor for the Contract Period, if there is more than a [ten percent (10%)] variance between:

- [the average monthly Paid claims under the Plan for the last [two] months of the prior Contract Period; and]
- [the average monthly Paid claims under the Plan for the first [ten] months of the prior Contract Period.]

CONTRACT TERMINATION

This Stop Loss Insurance Contract will continue in effect until the end of the Contract Period, unless coverage is terminated as set forth below.

This Contract and all benefits will terminate upon the earliest of the following dates:

- [on the due date of any premium which remains unpaid at the end of the Grace Period; or]
- [the premium due date next following receipt by the Company of written notice from the Policyholder that this Contract is to be terminated; or]
- [the date of termination of the Covered Person's Benefit Plan; or]
- [the date the Policyholder suspends active business operations or is placed in bankruptcy or receivership; or]
- [the date the Policyholder dissolves.]

This Contract may also be terminated at the Company's option on either of:

- [the date the number of Covered Units under the Covered Person's Benefit Plan becomes less than [fifty one] [seventy-five];]
- [the date the Policyholder fails to perform the Duties of the Policyholder as set forth in this Contract; or]
- [the date the Third Party Administrator is changed by the Company unless agreed to in writing by the Company.]

The Company will not refund any portion of the premium paid by the Policyholder whose Plan terminated during the Contract Period.

[AGGREGATE STOP LOSS]

COVERAGE PROVISION: If the Policyholder's Losses for the Benefit Period, stated in the Schedule of Stop Loss, exceeds the Annual Aggregate Attachment Point for the Contract Period, the Company will reimburse the Policyholder, subject to the terms and conditions of this Contract including the limits set forth in the Schedule of Stop Loss, an amount;

- equal to the Aggregate Percentage Reimbursable times the amount by which Losses exceed the Annual Aggregate Attachment Point; and
- not to exceed the Maximum Covered Person's Benefit Plan Losses per Covered Person per Benefit Period; and
- not to exceed the Maximum Aggregate Benefit per Benefit Period.

CONDITIONS: If a Policyholder's coverage terminates before the end of the Contract Period;

- the Annual Aggregate Attachment Point will be deemed not satisfied; and
- the Company will not be liable for any reimbursement.

CLAIM SETTLEMENTS: After the end of the Benefit Period, the Company will reimburse the Policyholder for the Aggregate Stop Loss within a reasonable period of time once satisfactory evidence of Payment of such Loss is received and approved by the Company.

While the determination of benefits under the Plan is the sole responsibility of the Policyholder, the Company reserves the right to interpret the terms and conditions of the Plan as they apply to this Stop Loss Insurance Contract. If Company finds that any Payment was not made in accordance with the terms of the Plan, or is not an eligible benefit under the Plan, the Company may exclude such Payment from Losses. The Company will have the sole authority to reimburse or deny Losses under this Contract.

[SPECIFIC STOP LOSS]

COVERAGE PROVISION: If the Policyholder's Losses for the Benefit Period, as shown in the Schedule of Stop Loss, exceeds the Specific Deductible, the Company will reimburse the Policyholder, subject to the terms and conditions of this Contract including the limits in the Schedule of Stop Loss, an amount:

- equal to the Specific Percentage Reimbursable of Specific Stop Loss times the amount by which Losses exceed the Specific Deductible amount; but
- not to exceed the Lifetime Maximum Specific Benefit.

CONDITIONS: Losses for any Covered Person during the Contract Period will be determined according to the Benefit Period as shown in the Schedule of Stop Loss.

The Specific Deductible amount as shown in the Schedule of Stop Loss applies separately to each Covered Person during a Benefit Period.

CLAIM SETTLEMENTS: The Company will reimburse the Policyholder for a Specific Stop Loss as herein provided, within a reasonable period of time once satisfactory evidence of Payment of such Loss is received and approved by the Company.

While the determination of benefits under the Plan is the sole responsibility of the Policyholder, the Company reserves the right to interpret the terms and conditions of the Plan as they apply to the Stop Loss Insurance Contract. If Company finds that any Payment was not made in accordance with the terms of the Plan, or is not an eligible benefit under the Plan, the Company may exclude such Payment from Losses. The Company will have the sole authority to reimburse or deny Losses under this Contract.



Nationwide Life Insurance Company

Home Office: Columbus, Ohio

APPLICATION FOR STOP LOSS INSURANCE COVERAGE

Application is hereby made to **Nationwide Life Insurance Company** ("Company") for [Aggregate] [and] [Specific] Stop Loss Insurance. This Application must be accepted and approved by the Company prior to any Contract being in effect.

1. Full Legal name of Policyholder _____

2. Key contact at Policyholder _____
3. Address _____
4. City, State, Zip Code _____

5. Subsidiary or affiliated companies (companies under common control through stock ownership, contract or otherwise) that are to be included. List legal names and addresses of such companies.

6. Other locations. Include City, State and Zip code.

7. Name of UR Provider and/or PPO Organization(s).

9. Nature of Policyholder's Business

☐ Corporation ☐ Partnership ☐ Proprietorship ☐ Other _____
10. Has the Policyholder ever voluntarily applied for relief in the Bankruptcy Court?
☐ Yes ☐ No If yes, explain

11. Enter the full name of the Policyholder's Benefit Plan

12. Name and address of Policyholder's Third Party Administrator

13. Proposed Effective Date _____

14. Total eligible Covered Persons _____ Estimated initial enrollment _____

[15. Are retirees covered? ___ YES ___ NO]

16. Deposit premium \$ _____

17. Writing agent or broker of Policyholder _____

Social Security No. or Tax ID _____

Address _____

18. Where is the Contract and other correspondence to be mailed? _____

Persons to be covered under the Stop Loss Contract: Covered Persons and dependents who meet the eligibility requirements as set forth under the Policyholder's underlying Plan, except a Covered Person or dependent who is listed in the Special Limitations section of this application or who is required to be disclosed in the Stop Loss Disclosure Statement - unless named on the Stop Loss Disclosure Statement and approved by the Company.

GENERAL SCHEDULE OPTIONS

A. AGGREGATE STOP LOSS ☐ Yes ☐ No

Benefit Period: Eligible Policyholder Losses from Plan expenses

Incurred from _____ through _____, and

Paid from _____ through _____.

[Losses Incurred prior to the Effective Date will be limited to the amount as set forth in the Schedule of Stop Loss.]

Coverages applying to Aggregate Stop Loss include (check all that apply):

☐ Medical

☐ [Prescription Drug Card Program]

☐ [Dental Care]

☐ [Mail Order Prescription Drug Card Program]

☐ [Vision Care]

☐ [Weekly (Disability) Income]

☐ [Other] _____

[Aggregate Percentage Reimbursable (excess of Attachment Point) _____%]

[Maximum Aggregate Benefit, excess of Annual Aggregate Attachment Point, per Benefit Period

\$ _____]

[Maximum Benefit Plan Losses per Covered Person per Benefit Period

\$ _____]

[Minimum Annual Aggregate Attachment Point \$ _____]

[Aggregate Terminal Liability Protection ☐ Yes ☐ No]

[Aggregate Premium per (month/annum/per Covered Person per month) \$ _____]

B. SPECIFIC STOP LOSS ☐ Yes ☐ No

Benefit Period: Eligible Policyholder Losses from Plan expenses

Incurred from _____ through _____, and

Paid from _____ through _____.

[Losses Incurred Prior to the Effective Date will be limited to the amount reimbursable as set forth in the Schedule of Stop Loss.]

Eligible expenses for Specific Stop Loss include (check all that apply):

- | | |
|--|--|
| <input type="checkbox"/> Medical | <input type="checkbox"/> [Prescription Drug Card Program] |
| <input type="checkbox"/> [Dental Care] | <input type="checkbox"/> [Mail Order Prescription Drug Card Program] |
| <input type="checkbox"/> [Vision Care] | <input type="checkbox"/> [Weekly (Disability) Income] |
| <input type="checkbox"/> [Other] _____ | |

Specific Deductible (per person)\$ _____

Specific Percentage Reimbursable (excess of deductible) _____%

Lifetime Maximum Specific Benefit \$ _____

(per Covered Person in excess of Specific Deductible)

[SPECIAL CONDITIONS AND/OR LIMITATIONS:]

|

GENERAL CONDITIONS

It is understood and agreed as conditions precedent to the approval of this Application that:

- The Policyholder is financially sound, with sufficient capital and cash flow to accept the risks inherent in a "self-funded" health care plan;
- The Third Party Administrator retained by the Policyholder will be considered the Policyholder's Agent and not the Company's Agent;
- All documentation requested by the Company must be submitted prior to any approval of this Application and must be received by the Company within [thirty (30) days] of the Effective Date;
- The Company will evaluate the Policyholder's risk, and may require adjustments of rates, factors and or special limitations to accommodate for abnormal risks;
- Premiums are not considered paid until the premium check is received by the Company and at the rates set forth in the Schedule of Stop Loss.
- If the Policyholder has more than one business location, a representative of the Policyholder knowledgeable of the Covered Persons at each location has reviewed and completed the Disclosure Statement.

In making this Application, the Policyholder represents that such information accurately reflects the true facts and that the undersigned has authority to bind the Policyholder to the proposed Contract. Accordingly, this Application, including the Disclosure Statement, will be a part of the Contract if accepted by the Company.

NOTICE:

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Plan sponsors of self-funded health plans should not consider the purchase of stop loss coverage and/or excess loss coverage as complete protection from all liability created by the self-funded health plan. Plan sponsors should be aware that the failure to comply with the terms of the stop loss policy and/or the provisions in the self-funded health plan may cause the plan sponsor to incur liabilities under the health plan. For instance, if medical claims are paid on an ineligible individual, the stop loss carrier may deny the reimbursement under the stop loss policy. In addition, the Arkansas Life and Health Insurance Guaranty Association does not cover claims reimbursable under a stop loss policy. [Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits application or files a claim containing a false or deceptive statement is guilty of insurance fraud.]

Dated at _____ this ____ day of _____, [YYYY]

Policyholder _____

Authorized Officer/Partner _____
Type or Print

Title _____

Signature_____

Tax ID #_____

Witness_____



Nationwide Life Insurance Company

Home Office: Columbus, Ohio

REQUEST FOR RENEWED STOP LOSS INSURANCE COVERAGE

Policyholder: _____

Effective Date: _____

Contract Number: _____

Contract Period From: _____

Enrollment for the first month of the New Contract Period:

[Single Covered Person] _____

[Covered Person & Child(ren)] _____

[Covered Person & Spouse] _____

[Covered Person & Family] _____

Persons to be covered under the Stop Loss Contract: Covered Persons and dependents who meet the eligibility requirements as set forth under the Policyholder's underlying Plan, except a Covered Person or dependent who is listed in the Special Limitations section of this application or who is required to be disclosed in the Stop Loss Disclosure Statement - unless named on the Stop Loss Disclosure Statement and approved by the Company.

A. AGGREGATE STOP LOSS ☐ Yes ☐ No

Benefit Period: Eligible Policyholder Losses from Plan expenses

Incurred from _____ through _____, and

Paid from _____ through _____.

Coverages applying to Aggregate Stop Loss include (check all that apply):

☐ Medical

☐ [Prescription Drug Card Program]

☐ [Dental Care]

☐ [Mail Order Prescription Drug Card Program]

☐ [Vision Care]

☐ [Weekly (Disability) Income]

☐ [Other] _____

[Aggregate Percentage Reimbursable (excess of Attachment Point) _____ %]

[Maximum Aggregate Benefit, excess of Annual Aggregate Attachment Point, per Benefit Period

\$ _____]

Monthly Aggregate Factors:

	Covered Person	Covered Person & Child(ren)	Covered Person & Spouse [/Domestic Partner]	Covered Person & Family
Medical	\$ _____	\$ _____	\$ _____	\$ _____
[Dental	\$ _____	\$ _____	\$ _____	\$ _____
				1
[Vision	\$ _____	\$ _____	\$ _____	\$ _____
				1
[Weekly Disability	\$ _____	\$ _____	\$ _____	\$ _____
				1
Other _____	\$ _____	\$ _____	\$ _____	\$ _____

[All coverages are combined for all determinations of Aggregate Stop Loss liability.]

[Aggregate Premium per (month/annum/per Covered Person per month) \$ _____]

[Aggregate Terminal Liability Protection ☐ Yes ☐ No]

[Minimum Annual Aggregate Attachment Point \$ _____]

[Maximum Benefit Plan Losses per Covered Person per Benefit Period] \$ _____

B. SPECIFIC STOP LOSS ☐ Yes ☐ No

Benefit Period: Eligible Policyholder Losses from Plan expenses

Incurred from _____ through _____, and

Paid from _____ through _____.

Eligible expenses for Specific Stop Loss include (check all that apply):

- ☐ Medical ☐ [Prescription Drug Card Program]
☐ [Dental Care] ☐ [Mail Order Prescription Drug Card Program]
☐ [Vision Care] ☐ [Weekly (Disability) Income]
☐ [Other] _____

Specific Deductible (per person) \$ _____

Specific Percentage Reimbursable (excess of deductible) _____ %

Lifetime Maximum Specific Benefit \$ _____

(per Covered Person in excess of Specific Deductible)

[Specific Premium per month:

	Covered Person	Covered Person & Child(ren)	Covered Person & Spouse [/Domestic Partner]	Covered Person & Family
Medical	\$ _____	\$ _____	\$ _____	\$ _____
[Dental	\$ _____	\$ _____	\$ _____	\$ _____
				1
[Vision	\$ _____	\$ _____	\$ _____	\$ _____
				1
[Weekly Disability	\$ _____	\$ _____	\$ _____	\$ _____
				1
Other _____	\$ _____	\$ _____	\$ _____	\$ _____

[SPECIAL CONDITIONS AND/OR LIMITATIONS:]

In executing this Renewal Request the Policyholder is acknowledging its acceptance of these new rates, factors and terms, as well as the conditions set forth in the Disclosure Statement prepared for this Renewal, and further acknowledging that, except as stated separately with attachments, all material facts and conditions previously stated regarding the Plan and this Contract remain unchanged. [The above rates, factors and terms will be subject to change if this Renewal is not received within [10] days from the beginning of the Contract Period stated above.

Dated at _____ this ____ day of _____, [YYYY]

Policyholder _____

Authorized Officer/Partner _____
Type or Print

Title _____

Signature _____

Tax ID # _____

Witness_____

Nationwide Life Insurance Company
Stop Loss Renewal Amendment

This Amendment is attached to and made part of the Policy specified below. It is subject to all of the Policy provisions that do not conflict with its provisions.

Policyholder:

Amendment Effective Date:

The Policy is amended as follows:

The Policy number is changed from _____ to _____

SCHEDULE OF STOP LOSS

Coverage specified herein is applicable only during the Contract Period from _____ to _____, and is further subject to all terms and conditions of this Contract, unless annotated below.

[AGGREGATE STOP LOSS] ☐ Yes ☐ No

Benefit Period: Covered Person's Benefit Plan Losses Incurred from _____ through _____, and Paid from _____ through _____.

[Losses Incurred prior to the original Contract Effective Date will be limited to \$ _____ and \$ _____ per Covered Person.]

Coverages applying to Aggregate Stop Loss include:

- | | |
|--|--|
| <input type="checkbox"/> Medical | <input type="checkbox"/> [Prescription Drug Card Program] |
| <input type="checkbox"/> [Dental Care] | <input type="checkbox"/> [Mail Order Prescription Drug Card Program] |
| <input type="checkbox"/> [Vision Care] | <input type="checkbox"/> [Weekly (Disability) Income] |
| <input type="checkbox"/> [Other] _____ | |

[Aggregate Percentage Reimbursable (Excess of Attachment Point) _____ %]

Monthly Aggregate Factors:

	Covered Person	Covered Person & Child(ren)	Covered Person & Spouse [/Domestic Partner]	Covered Person & Family
Medical	\$ _____	\$ _____	\$ _____	\$ _____
[Dental	\$ _____	\$ _____	\$ _____	\$ _____]
[Vision	\$ _____	\$ _____	\$ _____	\$ _____]
[Weekly Disability	\$ _____	\$ _____	\$ _____	\$ _____]
Other _____	\$ _____	\$ _____	\$ _____	\$ _____

All coverages are combined for determination of Aggregate Stop Loss liability under the terms of this Contract.

Maximum Aggregate Benefit per Benefit Period \$ _____
(Excess of Annual Aggregate Attachment Point)

Maximum Benefit Plan Losses per Covered Person per Benefit Period

\$ _____

Minimum Annual Aggregate Attachment Point \$ _____

Aggregate Premium per (month/annum/per Covered Person per month) \$ _____]

[SPECIFIC STOP LOSS

☐ Yes

☐ No

Benefit Period: Covered Person's Benefit Plan Losses Incurred from _____ through
_____ and Paid from _____ through _____.

[Losses Incurred prior to this Contract Effective Date will be limited to _____ per Covered Person.]

Coverage applying to Specific Stop Loss include:

☐ Medical

☐ [Prescription Drug Card Program]

☐ [Dental Care]

☐ [Mail Order Prescription Drug Card Program]

☐ [Vision Care]

☐ [Weekly (Disability) Income]

☐ [Other] _____

Specific Deductible (per Person) \$ _____

Specific Percentage Reimbursable (Excess of Deductible) _____

Lifetime Maximum Specific Benefit \$ _____

(per Covered Person in excess of the Specific Deductible)

Specific Premium per month: Covered Person Only \$ _____

Covered Person & Child(ren) \$ _____

Covered Person & Spouse \$ _____

Covered Person & Family \$ _____]

[SPECIAL CONDITIONS AND/OR LIMITATIONS:]

THIRD PARTY ADMINISTRATOR:

Dated at _____ this _____ day of _____ [YYYY]

Policyholder _____

Title _____

Witness _____

State:	Arkansas	Filing Company:	Nationwide Life Insurance Company
TOI/Sub-TOI:	H12 Health - Excess/Stop Loss/H12.001 Accident & Sickness		
Product Name:	Stop Loss		
Project Name/Number:	Stop Loss Filing/		

Supporting Document Schedules

		Item Status:	Status Date:
Bypassed - Item:	Application	Approved-Closed	01/30/2013
Bypass Reason:	The applications intended to be used can be filed in the Form Schedule.		
		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved-Closed	01/30/2013
Comments:			
Attachment(s):			
Read Cert.pdf			

CERTIFICATION OF COMPLIANCE WITH
INSURANCE POLICY SIMPLIFICATION REQUIREMENTS

Name and Address of Insurer:

Nationwide Life Insurance Company
One Nationwide Plaza
Columbus, Ohio 43215
Mail Code: 1-32-101

Policy/Certificate Form Number(s):

GSL AO L20 000 0312

Policy

GSL AO L24 000 0312

Rider

I certify that, to the best of my knowledge and belief, the policy/certificate forms are in compliance with the Flesch reading ease score and the other requirements set forth in the Insurance Policy Language Simplification Act of the State of Arkansas.



Syed S. Rizvi
Chief Specialty Insurance Officer

Date: January 24, 2013